



**Center for Health Information and Analysis
Public Records Request Form**

Contact Name _____
Company _____
Address _____
City _____ State _____ Zip _____
Email address _____ Phone _____
Fax # _____ TIN _____
(Tax Identification No for billing purposes)

Please check the type of record(s) you are requesting:

_____ Audited Financial Statement (Hospitals)
_____ Charge Book (Hospital)

Cost Report:

_____ Adult Day Health
_____ Community Health Center
_____ Hospital
_____ Nursing Facility (HCF-1)
_____ Nursing Facility Realty Company (HCF-2)
_____ Nursing Facility Management Company (HCF-3)
_____ Nursing Service Report
_____ Resident Care Facility (HCF-4)

Database:

_____ Hospital Cost Report Data
_____ Nursing Facility Cost Report Data
_____ Regulations/Public Hearings

Other (Please Specify) _____

To request multiple records, please list records in alphabetical order and specify year (attach additional sheet if necessary):

1. _____
2. _____
3. _____
4. _____
5. _____

Email, fax or mail completed form to:

Center for Health Information and Analysis
Public Records
Two Boylston Street, Boston, MA 02116-4704

Email: public.records@state.ma.us
Fax : (617) 727-7662
Phone: (617) 988-3105